TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Matthew Ferguson, M.D.

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-16-0044-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
September 8, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The submitted documentation does not include a position statement from the requestor.

Amount in Dispute: Not defined

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "… Texas Mutual has no record of receiving billing from the requestor for the dates above nor has the requestor provided any copies of billing and eobs for those dates."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 19 and August 11, 2015	Physical Therapy	Not defined	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes: No Explanations of Benefits were found in the submitted documentation.

Issues

1. Has a medical fee dispute been established in accordance with 28 Texas Administrative Code §133.307?

Findings

1. 28 Texas Administrative Code §133.307 (c)(2) requires the following in a request for medical fee dispute submitted by a health care provider:

> … The requestor shall provide the following information and records with the request for MFDR in the form and manner prescribed by the division. The provider shall file the request with the MFDR Section by any mail service or personal delivery. The request shall include:
> (A) the name, address, and contact information of the requestor;
> (B) the name of the injured employee;
> (C) the date of the injury;
> (D) the date(s) of the service(s) in dispute;
> (E) the place of service;
> (F) the treatment or service code(s) in dispute;
> (G) the amount billed by the health care provider for the treatment(s) or service(s) in dispute;
> (H) the amount paid by the workers' compensation insurance carrier for the treatment(s) or service(s) in dispute;
> (I) the disputed amount for each treatment or service in dispute;
> (J) a paper copy of all medical bill(s) related to the dispute, as originally submitted to the insurance carrier in accordance with this chapter and a paper copy of all medical bill(s) submitted to the insurance carrier for an appeal in accordance with §133.250 of this chapter (relating to General Medical Provisions);
> (K) a paper copy of each explanation of benefits (EOB) related to the dispute as originally submitted to the health care provider in accordance with this chapter or, if no EOB was received, convincing documentation providing evidence of insurance carrier receipt of the request for an EOB;
> (L) when applicable, a copy of the final decision regarding compensability, extent of injury, liability and/or medical necessity for the health care related to the dispute;
> (M) a copy of all applicable medical records related to the dates of service in dispute;
> (N) a position statement of the disputed issue(s) that shall include:
> (i) the requestor's reasoning for why the disputed fees should be paid or refunded,
> (ii) how the Labor Code and division rules, including fee guidelines, impact the disputed fee issues, and
> (iii) how the submitted documentation supports the requestor's position for each disputed fee issue;
> (O) documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) … when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable …

Review of the submitted documentation finds that the requestor failed to articulate, discuss, or explain the amount billed for the disputed services or the disputed amount for the services in question. The Division finds that the requestor has failed to establish that a medical fee dispute exists in accordance with 28 Texas Administrative Code §133.307 for the services in question.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Laurie Garnes	November 9, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.